The mission of AIS is to improve the health of the community and the world by setting the standard of excellence of stress management in education, research, clinical care and the workplace. Diverse and inclusive, The American Institute of Stress educates medical practitioners, scientists, health care professionals and the public; conducts research; and provides information, training and techniques to prevent human illness related to stress.

AIS provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides leadership to the world on stress related topics.
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Picture this: A combat veteran is getting publicly shamed. Their service is spat upon; various media outlets perpetuate misinformation about them; veterans’ charities and nonprofits exploit them; and the general public doesn’t seem to accept them either. They are criticized, scrutinized, and are often spoken about with disdain, question, and shame. The combat veteran faces constant antagonization and, as a result, experiences a failure to reintegrate after war and is vulnerable to homelessness, domestic violence, substance abuse, incarceration, and suicide.
No, this isn’t 1968. This is the beginning of
the 21st century. And that combat veteran
is a woman.

I found myself returning from Iraq in
late 2005 without any support, whether
in-home or in my community. I survived a
year of extreme violence in urban warfare
in the streets of Ramadi and facing perse-
cution at the hands of my command for
the color of my skin. Nothing, not even my
former passion for art, inspired me. The zest
for life I once had prior to deploying to Iraq
had vanished.

Since I was a child, drawing, writing,
painting, and even sculpting were my
passions— but so was psychology. My dream
as a military brat finishing high school in
the East Bay of Northern California in the
late 90s was to become an art therapist.
And since I was growing up in government
housing facing the Port of Oakland, Army
recruiters knew that the combination of
my family’s military history and my desire
to move on up the socioeconomic ladder
made for a great case to enlist.

At age 17, I enlisted as both a medic and
a mental health specialist, hoping to work
my way up the ranks in the Army to become
the best clinician I could be. They did not,
of course, explain to me how I’d be working
60 hours a week while trying to accomplish
my educational objectives. I did it anyway,
blergy-eyed and coffee-soaked to the bone.

By the time I received orders for Iraq, I was
halfway through college and upon my
return, I changed my major from psy-
chology to political science/international
relations. After all, how can one make a
difference in botched Middle Eastern
policy when many of our elected officials
— like most Americans — have never left
the country? I have, twenty-two times and
counting. I was a force to be reckoned with
in foreign policy debates throughout my
upper-level undergraduate courses, but
inside, I was empty.

After some thorough introspection,
I decided to paint again. After such a
gruesome experience, I had lost my
interest in art, as I did all other passions
and dreams. I felt numb, but I knew art
always had a way of unlocking a door into
new ideas and plans. Even if I didn’t want
to, I painted, wrote, sketched, and even
took part in Middle Eastern dance as a
hobby and side gig. While I made every
effort I could to feel something, any-
thing, again, I felt as though the wind was
blowing right through me. Nothing was
helping, and inside I knew I needed help.
The War on Women Veterans

One doesn’t have to look very hard to see not just the war on women, but the war on women veterans. Men are writing books protesting integrating women not just into combat arms, but the military all together. Women are willfully defending misogyny and are utilized as puppets for publicly disgracing women’s abilities, accomplishments, and honorable service. This, in turn, served as yet another barrier to reintegration and contributed to feelings of emptiness.

Women of color in particular are one of the fastest growing subpopulations of veterans. According to VA statistics in 2014, there are 2,020,077 million women veterans out of the total veterans population 21,999,108, making up 9.2% of today's veterans population. 214,098 currently serve on Active Duty, 118,781 in the Reserve, and 72,790 in the National Guard.

Challenging negative stereotypes, facing barriers to care, and fighting for equality all take its toll on the psyche in addition to struggling to readjust to the civilian world.

As a female combat veteran, I have spoken up quite a bit about this and have been pushed aside and silenced. I’ve been there, done that. Yet I get a clear view of a nonstop circus shredding my service apart quite vividly. In these boots, one struggles in finding any real reasons to continue living in such an environment with no apparent and attainable way out. According to the US Department of Veteran Affairs, women veterans under the age of 30 commit suicide at nearly 12 times the rate of non-veterans. With all the misogyny women face in general, in addition to being ostracized for combat service, is it any surprise that women veterans are committing suicide at alarming rates?

Los Veteranos de Arizona

After a nasty divorce that left me stranded in Central Massachusetts, I made a solemn vow to live my life for me and no one else. After a workshop in Arizona that allowed me to briefly escape the bitter winter weather of New England, I decided I would find a way to move to Phoenix and start anew.

Knowing no one in Arizona meant I would start with a new canvas in life and I would select the colors for a happier, brighter chapter – much like the jaw-dropping, beautiful Arizona sunset.

The Arizona State Women Veterans Coordinator at the time, Gabe Forsberg, reached out to me and helped me secure
a position in Phoenix. A few weeks later, I packed clothes and books into my tiny silver Kia Spectra, gave away all my other belongings and furniture and got on the road to the rest of my life. From Massachusetts to Arizona, this road trip changed my life and opened my eyes to the beauty of the picturesque American West. The dramatic colors, the craggy purple mountains kissed by turquoise and orange skies enveloped me and urged me to get back to painting ASAP.

Upon my arrival, Gabe welcomed me with open arms and introduced me to an arts group after catching sight of some of my drawings I carried in my notebook. The arts group, Los Veteranos de Arizona, was led by a Vietnam Veteran named Jim Covarrubias of Ariztlan Studios in downtown Phoenix. Los Veteranos de Arizona was comprised of predominantly male Native American and Latino combat veterans of the Vietnam War era.

At first I was apprehensive about joining any veterans group. After all, so many white male-dominated veterans’ groups and nonprofits basically blew me off, spied on me, or slandered me to keep voices like mine away while holding onto submissive women with pretty faces and low self-esteem. Gabe intervened and talked with Jim Covarrubias in hopes of getting a positive response and proving my pessimism wrong. Gabe suggested I give it another chance, and for this group in particular.

“What makes you so confident that they’d accept a female combat veteran whose heritage is from a remote Pacific Island? I’m not ready for more bullshit or political games,” I sneered.

“I’m confident – especially after their response. They said you are fully welcome, because while they don’t know what it’s like to walk in your boots as a woman, they know what it’s like to come home and have your military service shamed or ignored, and how lonely it can be especially due to the color of your skin," she said. That was probably the best response I’ve ever heard from a male group in regard to women veterans.

Los Veteranos de Arizona members were original, sincere, and best of all, they were passionate artists too. They were incredibly supportive to the point where they convinced me to show my work for a veterans day exhibit, and show art which I had held onto for years, in a public setting. No pissing contest of ‘who did what and when’ that you often see with the OIF/OEF crowd. While Iraq and Afghanistan veterans groups snubbed me to maintain their boys’ club status quo, Vietnam veterans groups, especially those of color, took me in. They just allowed me to be me and did not judge me. And really, that’s all I ever wanted.

The Colors of Trauma

Upon entry into Los Veteranos de Arizona, Jim proposed a challenge to all artists. We were not expected to make “safe” art. What this meant was that we were challenged to do more than draw or paint bald eagles, American flags, or any other predictable patriotic symbol. No. Jim wanted us to artistically address the memories that bothered us most in addition to parts of our heritage that helped us survive.

Taking the challenge seriously, I drew the memories that haunted me the most: the faces of children in the midst of war. It wasn’t whirring helicopter blades, rocket-propelled grenades, bloodied corpses,
or IEDs that kept me awake through the early morning hours. It was the petrified expressions of children, even their joyous expressions while standing in rubble playing with trash like surrogate toys, that haunted me. So I drew and painted them.

I lost days of sleep as I finished the works of art. I cried every night. I looked at photos of Ramadi, filled with remorse and guilt that I could have done more to help or save lives. However, upon completion, something strange happened. I felt lighter. It felt like I had taken off a layer of armor, psychological Kevlar that weighed me down. These memories of children suffering were now on paper, validated, and no longer owned me. I owned these memories and had control of them. In accepting Jim’s challenge, I arranged my traumatic thoughts like artwork in a portfolio.

While trauma from war was part of the journey through PTSD, so was toxic leadership. Throughout my time in Ramadi, Iraq, I was also harassed, threatened, and falsely accused of a crime I didn’t commit. After turning in my predominantly white supremacist command in Baghdad’s Green Zone to the Inspector General, they were permitted to retaliate against me. In the end, I was able to save myself through photos and documentation and charges of Mutiny were reduced to an Article 15, a slap on the wrist for disrespecting an officer after she stranded one of my soldiers in the middle of a medical evacuation.

While the military has enlisted individuals from many races and cultures, through all the wars the United States was involved in, people of color have also experienced discrimination. Whether it was all-Black units starting from the Revolutionary War, Tuskegee Airmen, Navajo Code Talkers, Japanese “Nisei” in WWII who fought in 442D Regiment in European theater, or Puerto Rican Borinqueneers, racial persecution is
nothing new in the military. When I enlisted, drill sergeants told us all that we were simply varied shades of camouflage, brothers and sisters – but Iraq proved that this was simply not a shared sentiment in the ranks.

There has been one study of racism experienced in the military and the relationship to war-related PTSD. Asian American Vietnam veterans (Loo et al., 2001) were examined with the Race-Related Stressor Scale (RRSS), a questionnaire that assesses exposure to race-related stressors in the military and war zones.

The findings concluded that experiencing racism from fellow service members while deployed to a combat zone was the most significant stressor associated with the development of PTSD— even more so than exposure to combat stressors; hence revealing how damaging racism committed by fellow American service members has been to date.

Minority Vietnam veterans around me knew not only of being shunned and judged upon return to the United States, but also the discrimination faced due to their race. In addition to a group of women scattered across the country who never stop caring for women veterans like me, Vietnam veterans of color have been one of the most supportive groups of me as a female combat veteran. They not only served in severely traumatic environments, they were treated as outcasts - and dealt with everything female combat veterans have been experiencing outside of gender-bashing.

While people nowadays are far more supportive of “the troops” in general, it still tends to be male-centric. Just take a look at your local community resources and what’s really there for women. Give those resources a call and put them to the test if they offer anything for women. You’re in for a real treat. Despite studies that show that women perform effectively in combat and that there is no real difference in handling PTSD when it comes to gender, we’re still slammed quite openly, even in this flag-waving, yellow ribbon-wearing environment. Vietnam veterans I’ve worked with seem to get that and see history repeating itself under a different banner.

It’s not just about resources and emergency services, it’s about addressing the problem with long-term solutions. Not just waving the flag and slapping on bumper stickers, but offering chances to improve, develop, and contribute to society with pride and dignity without dealing with current judgment and public humiliation. However, in order to establish adequate resources for women, we must address everything that involves root causes of our problems first.
Throughout Scottsdale, Phoenix, and Chandler, Los Veteranos de Arizona held art shows that attracted not only veterans, but curious civilians, actors, protestors, and people of all walks of life. One Vietnam veteran emerged from the art-devouring herd and approached me, inquiring about my artwork. He had also apparently heard from the Veteranos that I had trouble with other veterans’ groups from my era.

“Do you think those people care about you? Those shiny Iraq veteran groups and the VA? People who pretend to be your allies and hate you as much as you now hate them?” he asked, seeming to have an idea of the answer already.

I smirked, and shook my head. No, they don’t.

“Do you think they’d band together and give back all those medals that your Army officers stole from you? Would it be enough to remind you of your integrity and courage?” I looked at him with a hardened gaze, with the bitterness in my heart pouring through my dry eyes.

“You don’t need their validation to see your worth, soldier. Just take a good long look in the mirror, and that’s all you’ll ever need to know. No lip service or ignorant bullshit is going to erase what you did, even when no one was looking or appreciated you,” he said.

Looking into his eyes, I smiled in confirmation, and nodded.

“Well, when you put it like that, I sound like less of a patient and quite possibly normal!” she laughed.
“You are normal. What happened to you wasn’t and you responded accordingly and made mistakes. We all have to find ways to not let trauma or illness define us as people.”

“Look at this, Michelle. Can you really call what I do fine art? I don’t know all the rules of art,” she replied.

“Fine art is the discipline of breaking rules. Pay no mind to those artists you’ve learned from in school. You have to find your own way through art as through trauma, and uncover your personal truth. That is where you uncover the beauty that has been within you all along,” I said.

She smiled, and returned to her project.

Artistic Release of Pain

Many great artists experienced harsh life experiences, ranging from deaths in the family, disability, or social ostracization.

This sense of post-traumatic growth implied to me that while some of my fellow veterans were falling apart and, in turn, committing suicide, I was here creating. Creating in a group of other hurt people from all walks of life who were piecing their lives back together at various ages, and recovering from abuse, sexual assault, drug use, or other forms of ailments and unfair hand of cards dealt to them. Among them, I didn’t feel as though I was above them, but walking with them side-by-side. In many ways, I was engaged in the act of support, a form of support that I had craved since returning from Iraq and didn’t find. I didn’t want anyone to feel the loneliness and isolation I felt. I was in the act of dealing the prescription I believed in most: art.

Innovative art and adversity seemed to go hand-in-hand, and the trauma that was previously eating me alive was now continually transforming into my muse. Before moving to Arizona, I had winced at taking hold of my past experiences for fear of them becoming overwhelming and owning me. Yet wielding a brush against a blank canvas, I was owning my trauma right back and taking ownership of everything that had transpired as moments in time that occurred but did not possess the best of me.

The events that occurred in my life, events in which I had no consent and for which others were not held accountable, were not my fault. Yet, I corralled all such horror and pushed them onto canvas, like toxins leaving the body through activated charcoal. A purging via art was ongoing and
the days where I cringed at Army mental health clinicians handing out psychotropic meds like candy, with no regard for tardive dyskinesia, suicidal tendencies, or other harmful side effects on patients, were no longer my reality.

While I had no doubt that DOD and VA mental health were persistently peddling drugs, I was pushing creative healing. I finally had results within my grasp that not only worked for me personally, but was working for the dozens in my care on a daily basis. Any naysayers suckling from the teat of pharmaceutical giants were instantly regarded with the same smug grin I received for questioning their practices.

Stigma & Silence

Discussing mental illness, or even such treatments, often came with stigma. Stigma’s power lies in silence. There is the silence that persists when discussion and action should be taking place. The silence one imposes on another for speaking up on a taboo subject, branding them with a label until they are rendered mute or preferably unheard.

I encouraged my group of artists to find their voice, to speak in spite of stigma, so that others may be invited to do the same in a safe space. Getting past the stigma was, more often than not, the first hurdle to artistic block. The pressure of judgment and the need for acceptance needed to be addressed.

In the presence of pressure, some people focus and some people fold.

The perception of opportunity in the midst of chaos is a habit that was being instilled within my studio. Not every light at the end of the tunnel was an oncoming train, as some of my clients joked. Developing an open-mind to both trauma and creativity was key to ensuring that this habit of persistence remained.

In order to love oneself again is to embrace all the oddities that make us unique individuals. To my clients, I wasn’t merely the war veteran or the psychosocial rehab arts instructor; I was Michelle, the sarcastic surrealist who played “Closing Time” when it was time to clean up art supplies and go home. I was a unique person telling them it was okay for them to be unique people too. I was more than the war, and they were more than their war within.

Uniqueness is a launch pad into other creative ventures and one no longer needs to search far for inspiration when one
trusts their intuition and instincts. There is plenty in the world that inspires awe, disgust, happiness, and melancholy. Trauma has a way of taking a hammer to reality and smashing it to bits, along with one's sense of identity and the world as one once knew it.

The Hammer

Everyone in this clinic was well-acquainted with the hammer, but it was our job as behavioral health art instructors not to drone on about the hammer or wax poetic about the shards of glass. Our job was to hand them the Modge Podge and glue, sans judgment, in order to piece themselves back together and tell them it was okay to have been broken; only to find oneself as a marvelous creation again.

Trauma doesn't always equal artistic inspiration, but the shaking of anyone's foundation, plus the confident embrace of one's identity, can surely lead to outstanding, innovative work that is both healing and gratifying. Trauma may often indicate symptoms of mental illness or worse, but it can also indicate a form of cognitive flexibility taking place in the creation of art. The ability to see things differently, and to solve problems severe enough to potentially lead to suicidal ideations, was an amazing feat.

Art is a powerful instrument when it comes to communicating the aftermath of trauma, whether it’s physical or psychological. For me, it was combat and imperial prejudice. As a female combat veteran, it was especially difficult to make the transition back into the US after spending a year in one of Iraq's most dangerous cities, Ar Ramadi.

Upon returning from a year of deaths, injuries, seeing some of the most glorious and hideous aspects of humankind in an uncensored montage, many judged me for what I had done (in their minds) without even asking me, as well as insulted me using gender-related or racial remarks. I knew the hammer as well as my clients, but it was my responsibility to help them put more tools in their coping skills toolbox.

To paraphrase Abraham Maslow, “If the only tool you have is a hammer, you treat everything as if it were a nail.” Survivors of trauma may be tempted to use any hammer-like weapon to combat any threats, real or perceived, but it's important to learn that there are other more effective tools to solve problems and to communicate.

Locating the Pressure Valve

Looking back on my return, I realized that the tremendous amount of pressure in my homecoming was much like a powder keg. For the first few years, I was going through the motions, not processing what I felt, dangerously nearing a breaking point. However, I was fortunate that I was aware that art was my personal pressure valve. Slowly, I felt warmth return to my veins via creativity. Art was giving me a transfusion.

Eventually, since following my dream of moving to the Southwest, my artistic talents truly blossomed. Before I knew it, I was creating depictions of the most painful memories, which reignited a state of insomnia, but launched into a new level of artistic fervor. Then my art turned from wartime trauma to politics, which have been laced with both humorous satire as well as sharp criticism. Now, I'm also focused on the surreal beauty of the desert.

With military veteran friends and former colleagues suffering from mental illness
and turning to over-medicating practices provided by the Department of Veterans Affairs and Department of Defense, doling out a litany psychotropic medications and narcotic painkillers to anyone who asked, I was deeply troubled. This wasn’t natural.

While I have stared into combat’s abyss, I can proudly say that I took the road less traveled. I followed my heart back to art where I could both express myself and ease my pain, venting my troubles through pens, paintbrushes, and clay, validating my experiences on my own terms with a finished masterpiece in the end. Art truly saved my life.

**Expressive Arts & Coping**

Although expressive arts therapy or artistic psychosocial rehabilitation lacks extensive research, it certainly has demonstrated a variety of creative and effective means for approaching and treating PTSD-related symptoms – combat-related or not (Spiegel, Malchiodi, Backos, & Collie, 2006). Instead of masking the pain with psychotropic medication, art as a therapeutic intervention aims to address the underlying psychological trauma and related symptoms.

Much like this article, writing can also prove to be cathartic and is another creative outlet to utilize as a positive coping mechanism in symptom management. According to Judith Pizarro (2011) in The Efficacy of Art and Writing Therapy: Increasing Positive Mental Health Outcomes and Participant Retention After Exposure to Traumatic Experience, studies have shown that writing decreased social dysfunction whereas art improved overall mood in psychosocial rehabilitative settings. The combination of both writing and illustrating appear to be promising for not only processing trauma, but elevating mood, motivation, and greater likelihood for recovery.

After working with other veterans as well as severely mentally ill clients, and encouraging them to express themselves through artistic, literary, culinary, musical, and other creative means, I’ve seen the most dramatic, positive changes in well-being. Such transformations could not be accomplished through prescription drugs or any other poisonous substances, which are designed to further numb the senses and keep one from embracing personal truths and ultimately discovering one’s own path to healing.

As a result of continuing on this creative path, I have reclaimed my life one artistic step at a time, and found my way out of a personal abyss by refusing to be a victim of trauma. Instead, I am an artist – who happens to be a survivor.

This piece is an excerpt from M.B. Dallocchio’s forthcoming book, “The Desert Warrior.” Artwork featured in this article are productions by M.B. Dallocchio and are available at www.mbdallocchio.com

M.B. Dallocchio is an artist and social worker with 15 years of experience in inpatient and outpatient mental health in both the nonprofit and military mental health sectors. She served in the US Army between 1998-2006 as a medic and mental health sergeant. As a former member of Team Lioness (a team of women attached to Special Forces and Marine infantry units in Iraq). While deployed to Ramadi, Iraq in 2004-2005, she was one of the first women to engage in direct combat operations. She is a David L. Boren NSEP Scholar and wrote the “Women Warriors” chapter in War Trauma and Its Wake (Routledge, 2012). She was featured in the San Francisco Chronicle, New York Times, NPR and many other outlets covering the female combat veteran experience. She has also been featured in the documentaries “Lioness” and “The Long Road Home.” After a long road of post-war reintegration, she received her Master of Social Work degree from University of Southern California in 2016. She currently works at University of Nevada Las Vegas. You can follow her on Twitter @MBDiallocchio and for more information, visit www.thedesertwarrior.com.
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Sex and intimacy issues can have a dramatic impact on any couple’s relationship. Add the military component, along with combat exposure, and chances for sexual dysfunction, emotional numbing, and divorce increase exponentially (Hirsch, 2009). Relationships shattered, families torn apart, and reintegration failures can possibly be prevented if VA Health Care would incorporate sexuality and intimacy-related therapy into ongoing veteran treatment.

Sex and intimacy certainly appear to be vital pieces of the post-war reintegration discussion, but according to VA mental health clinicians, it is just not happening. Dr. Jessica Punzo, a psychology fellow at the San Diego VA and Dr. Linda Mona at the Long Beach VA, insist that veterans, with or without children, are struggling with sexual and intimacy issues, which undeniably impact intimate relationships and family dynamics (Cramer, 2015).

A healthy sex life with intimacy is conducive to a healthy, satisfying life. VA avoidance of the discussion of sex and intimacy beyond a mere question on an intake form, is reflected
in VA benefits policies that exclude care for “sex therapy, sexual advice, sexual behavior modification or other similar services” (Veterans Health Administration, 2013). In order to achieve a successful post-war reintegration, sexuality and intimacy must be part of the conversation at VA and for any and all clinicians working with combat veteran relationship issues.

**In Love and War**

Sexual expression in previous wars is quite different from what it is today. During the American Revolution and Civil War, prostitutes were considered as “outlets” for sexual relief and in other cases, families could potentially accompany Soldiers to various posts (Rees, 1996).

In World Wars I and II, documentation of brothels for Service Members were not uncommon, in addition to German and Japanese propaganda taunting military personnel about their relationships back home as fragile and in danger during their absence (Fussell, 1989). However, in recent wars in Iraq and Afghanistan, predominantly Muslim countries, brothels were less apparent, but rape and human trafficking were still very much present (Hynes, 2004).

While we see these images of women being used as prostitutes, property, or place holders for absent men, what we have failed to discuss is the elephant in the room called intimacy. When enemy combatants, prostitutes, fellow Service Members, or women waiting on the home front for their spouse are not viewed as valued individuals – or human beings for that matter – intimacy has already gone AWOL.

When it comes to what women veterans deal with in dating, relationships, sex, and marriage, they are almost always excluded from this aspect of reintegration. According to Zinzow et. al., (2007), women veterans experience higher rates of exposure to traumatic incidents than the general public and are as likely to be exposed to combat as male veterans. However, in the mainstream media and in various communities across the country, this is not being accurately depicted. The deficits in understanding the various problems women veterans face are directly reflected in the severe lack of client-centered resources for women.

Are we asking too much from VA Health Care to look beyond symptoms of war and look at how love and intimacy - or the lack thereof - impacts morale, identity, psychological and physiological healing, and lasting reintegration success? To negate the inner workings of the home front and the interpersonal, regardless of marital status, is a grave mistake being perpetuated by VA Health Care and veterans’ nonprofit organizations offering mental health services.

**Sexual Adjustments in Returning Veterans**

Lengthy separation from partners can certainly take its toll on not only the relationship during the deployment, but everything that happens in the homecoming process as well. When military personnel experience an extended lack of physical or verbal intimacy in meaningful relationships, a number of issues have the potential to arise.

If the veteran is in a committed relationship, role changes occur over the course of separation, as well as when facing military discharge and entry into the civilian sector full-time. When unemployment is an issue for either partner, this can also impact both renegotiations of roles and emotional intimacy.

After war, feelings regarding sex can change. Have feelings changed regarding trust, feeling loved, important, valued? All of that is possible. Changes in physical interaction, secondary to trauma or other psychiatric problems, can occur in addition to body image issues, feelings of guilt and low self-worth, or memories of traumatic events experienced during military service.
Whether the issue is erectile dysfunction or a mood disorder, issues that affect intimate expression and sexual intercourse can create quite the complex case. Psychiatric symptoms, physiological injuries such as amputation or Traumatic Brain Injury (TBI), or changes in attitudes or beliefs regarding sex and intimacy can have dire consequences that undoubtedly negatively impact a military or veteran client’s life in the post-war reintegration process (VHA Office of Public Health and Environmental Hazards, 2010).

In order to proceed into talking about sex, intimacy, and communication, we must be willing to accept combat exposure as a direct cause of sexual dysfunction and psychological stress. After we take this into account when considering current divorce rates, suicide attempts and completed suicides, and other reintegration failures, we can start looking into what works and what does not work for those who have survived combat and have trouble relating to others on an intimate, interpersonal level once they return home from war.

**PTSD, TBI, and Sex**

The impact of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) on relationships can be manifested through marital issues, separation, divorce, parenting difficulties, maladaptive behaviors, family dysfunction, domestic violence, and reintegration failures (Matsakis, 2007). All of these negative responses and outcomes can be tied directly back to the couple and interpersonal instability. When sexual dysfunction and intimacy deficits appear, underlying issues of anger and psychiatric symptoms are often associated with the root causes (Begic, 2001).

The prevalence of PTSD and sexual dysfunction stand between 63-80 percent among combat veterans (Cosgrove, et al., 2002). All aspects of interpersonal interaction, physical and emotional, are affected by this comorbidity and manifests in sexual disinterest, Erectile Dysfunction (ED), premature ejaculation, decreases or failure in orgasm, lower sex drive, dissatisfaction, and other negative responses or behaviors (Cosgrove, et al., 2002). Difficulties in sexual intercourse and intimacy are common with many forms of injuries. Reported, 60 percent of individuals with TBI will have some form of sexual dysfunction. The greater the injury, the higher the possibility of experiencing sexual dysfunction – whether physiological or psychological (Katz & Aloni, 1999). TBI and sexual dysfunction may also lead to difficulties in initiating and following through with sexual intercourse, as well as interpersonal communication in general. In order to achieve a truly satisfying sex life, a healthy understanding of intimacy is imperative.

Some of the most common issues for individuals with TBI may include, but not limited to, decreases in sexual function and drive, difficulties in reaching orgasm, discomfort or decreased sensation during intercourse, and emotional disconnection.

While various studies have concluded that 40-60 percent of male veterans have problems with ED after TBI, and 33 percent experience difficulty in achieving an orgasm, there still seems to be a lack of data regarding women. Women who have served in combat and related sexual and intimacy data appear to be missing from many of these studies that include only extensive data on male sexual function.

So, what are the issues with women? In effort to understand what is happening with the entire PTSD/TBI veteran population regarding sexual health and social functioning, women must be included in any related studies. The ongoing objectification of women, in or out of the context of war, is a core part of rape, domestic violence, and other forms of direct and institutional violence (Carr, Green, & Ponce, 2015). If a male is experiencing difficulties in sex and intimacy because he no longer views his partner with respect, this can certainly be tied to violence against women before, during, and after war. When sex is more about domination and subjugation, then intimacy is completely lost and sex becomes dysfunctional and dangerous.
When Intimacy is Damaged

Sex and intimacy are relevant for understanding risk regarding social and psychological difficulties such as intimate partner violence. When resources vary for married or single Service Members and veterans, identifying risks and treating underlying issues becomes far more elusive. Mental health programs need to target different subgroups of military and veteran personnel based on their specific needs. Both marital status and gender must be examined with respect to mental health problems and intimate partner violence in order to determine the appropriate interventions, in addition to preventing intimacy issues before they explode post-combat.

The impact of PTSD and TBI on relationships in general appears to have negative effects on interpersonal issues (marriage or relationship), relationship breakdowns (divorce, break-ups, separation, custody battles over children), difficulties in maintaining healthy parenting with children, family discord, and interpersonal violence – whether physical, verbal, or psychological (Cosgrove et al., 2002). When families are not functioning well, especially due to combat-related PTSD and TBI, we then become acutely aware of issues in readjusting to post-war everyday life. From reunion stress to sexual dysfunction or emotional withdrawal, the burden of war trauma becomes far too cumbersome for any individual to manage alone (Manguno-Mire et al., 2007). Comorbid disorders also factor in to the complexity of sexual health and intimate communications, to include depression, chronic pain, anxiety, sleep disorders, neurological injuries, and other pre-existing disorders.
Intimacy, when damaged or absent, can lead to a variety of problems in addition to symptoms related to combat-sustained injuries. However, if intimacy, communication, and the nature of a healthy sex life can be addressed in conjunction with other post-war reintegration issues, we may be closer to closing the gaps in care and decreasing intimate and personal violence.

Sexual Healing

While couples struggling with sex and intimacy issues may attempt to seek care through a local VA Vet Center, for example, chances are very slim that a certified sex therapist will be on staff to assist them in specific issues pertaining to sexuality and intimacy. According to the American Association of Sexuality Educators, Counselors and Therapists (AASECT), certified sex therapists “are mental health professionals, trained to provide in-depth psychotherapy, who have specialized training in treating clients with sexual issues and concerns.” They handle both “simple sexual concerns” and “are prepared to provide comprehensive and extensive psychotherapy over an extended period of time in more complex cases.” A quick search through the AASECT website confirmed a lack of certified therapists working directly with veterans at VA-affiliated facilities.

Most recently, Iraq and Afghanistan veterans have endured polytrauma and complex injuries resulting from combat. Medical advances ensured higher survival rates from blast injuries, gunshot wounds, burns, and other physiological and psychological injuries. This complexity increases when issues of sexuality and intimacy come into play, and may deteriorate efforts at interpersonal intimacy when left unaddressed (Taft, Watkins, Stafford, Street, & Monson, 2011).

Injuries ranging from PTSD to TBI can impact one’s daily life both interpersonally and professionally (Ponsford, 2003). However, the issues of emotional numbing, extremes in sex drive, sexual dysfunction, fertility, interpersonal trust, sexual identity, intimacy, and objectification are often omitted from discussions and research pertaining to military/veteran mental health. The omission of sexuality and intimacy along with institutional biases against sex therapy present a sizable barrier to those seeking adequate mental health services (Weeks, 2005) Hertlein, Weeks, & Gambescia, 2015).

Change can, in fact, occur if VA policy changes and certified sex therapists are included in the qualified mental health professional recruitment in VA Health Care. Couples therapy and/or individual therapy may assist this population in adjusting, but the gender-bias must also be discussed and managed appropriately by professionals who are genuinely concerned with client-informed and culturally-competent care.

In December 2014, The Bob Woodruff Foundation hosted an event in Washington, DC entitled, “Intimacy After Injury.” While male veteran issues regarding genitourinary (GU) injury and infertility were closely examined and discussed with care, women veterans were largely excluded. In the foundation’s 2015 annual report from the conference, women veterans are only mentioned four times in a very general, broad context throughout the entire 25-page report. Male genitorurinary injuries, on the other hand, were mentioned at least 23 times specifically throughout the report.

In order to help couples move from dysfunctional states toward functionality regarding sexuality and intimacy, institutional biases must be addressed. Through adequate research, open discussion, and connecting with certified professionals who specifically deal with sexuality and intimacy issues, we can begin a dramatic shift toward incorporating it into the reintegration process and ongoing treatment services. Additionally, any program, VA-affiliated or not, that treats veterans should incorporate sex and intimacy questions into
the initial intake and assessment process to engage military and veteran couples and provide a healthy discussion for overall care (Snyder, Gasbarrini, Doss, & Scheider, 2011).

**Working It Out**

According to the *Maltz Hierarchy of Sexual Interaction*, sexuality and intimacy are channeled in “destructive or life-affirming ways” (Maltz, 1995). In determining positive (i.e. fulfillment, genuine intimacy) or negative (objectification, abuse, etc.) sexual interaction, a sex therapist can help military and veteran couples explore issues pertaining to the origins of trust, safety, intimacy, communication, and peak sexual experience (Maltz, 1995).

Couples may explore, with the guidance of the therapist, obstacles tied to current distress, sexual dysfunction, emotional numbing, and other symptoms that are connected to both TBI and PTSD (Nunnink, Goldwaser, Niloofar, Nievergelt, & Baker, 2010). Topics such as masturbation, for example, may be difficult to discuss at times, but opening the discussion of self-pleasure versus intercourse could provide additional insight into defining what sexual satisfaction means for the individual (Hurlbert & Whittaker, 1991).

While the *Maltz Hierarchy of Sexual Interaction* is often used in sexual education for couples, it can also assist the therapist in identifying other interpersonal issues in a parent-parent relationship. According to Schnarch (1997), passionate interpersonal intimacy, both physically and sexually, requires each person in the couple to face the anxiety of defining oneself, while developing the relationship with their partner. Schnarch refers to this process as differentiation, and highlights the need for a deeper understanding of the self and defining the self before true intimacy can be experienced with one’s partner.

Ultimately, military and veteran couples, where one or both individuals experienced combat exposure, are challenged with relating to one another when two recurring factors persist: when identity is not clearly defined and trust is not established. As a result, physical and emotional connection and sexual expression suffer when intimacy
and self-actualization are neglected within an intimate relationship. Both of these issues certainly pertain to the post-war reintegration process, which ties sexuality and intimacy to the Maltz Hierarchy of Sexual Interaction as a theoretical framework for understanding levels of sexual dysfunction.

Intimacy, Sex, and Psychoeducation

Sexual adjustments in veterans who have experienced combat tend to face a variety of issues that impact intimacy and communication. Extended periods of separation, roles changes, definitions of sex evolving at different paces for each partner, communication difficulties due to trauma, and body image contribute to the initial phase of reintegration and adjustment. When OIF/OEF veterans experience physiological and psychological trauma, the meaning of sex and intimacy can certainly change and the definition of self may lose meaning upon exit from a combat theater into civilian society.

Psychoeducation for military and veteran couples is essential to developing a sound understanding of the impact of combat exposure on interpersonal dynamics. When there is distance between two people – geographic or emotional – maintaining feelings of trust can be a challenge. That distance can either become a long-term issue or lead to relationship breakdown.

While symptoms of PTSD, for example, can contribute to feelings of distrust in others or immediate environment, this can also be applied to platonic and intimate relationships. In an age of exceedingly high divorce rates nationwide, fidelity is another aspect of trust that needs to be addressed and defined between the individuals in the relationship.

Defining fears and desires relating to intimacy may give the opportunity for introspection and open the path of communication with one another. This can, in turn, provide more psychoeducational moments where the couple not only learns about what love, sex, and intimacy mean to them as individuals, but also understand what the other person needs and then proceed accordingly.

While combat exposure and related injuries suffered during OIF/OEF may readily contribute to issues with sexuality and intimacy, prior trauma pre-dating war can also impact interpersonal dynamics. The co-occurrence of sexual assault, in childhood and/or adulthood or other forms of interpersonal violence, can negatively affect the military/veteran couple transition and progress when paired with PTSD, TBI, or other combat-acquired injuries (Campbell, Greeson, Bybee, & Raja, 2008).

In addition to cognitive behavioral and psychoeducational strategies, couples and individuals could also benefit from exploring various definitions of sexual expression, experimenting in what works for them personally, and opening communication when it comes to sexuality and intimacy.

Physical pain may also play a role in readjustment, and developing an
understanding of both pain management and medication management would be imperative in treatment. Side effects of pain and medication on sexual function and adjusting accordingly can also be facilitated through psychoeducation and understanding what each person in a relationship needs and how to express it.

**Evidence-Based Intervention**

Military and veteran couples facing difficulties with sexual dysfunction and intimacy after war should be afforded the opportunity to seek assistance through an AASECT-certified sex therapist for thorough psychotherapy. Evidence-based approaches that may be considered include: Creating Lasting Family Connections Marriage Enhancement Program (CLFCMEP), Emotionally Focused Couple Therapy, and Cognitive-Behavioral Conjoint Therapy (CBCT) for PTSD (Johnson, 2002) (Monson & Fredman, 2012) (SAMHSA, 2016).

Intervention options should have relationship skill building along with means to address combat-related trauma through the interpersonal development with one’s spouse. While CLFCMEP can be used to address conflict resolution, mindfulness, and trust, it may not fully explore issues pertaining to sexuality and identity as in sex therapy.

However, Emotionally-Focused Couple Therapy and CBCT have similar features and may suggest the non-sex therapist acquire additional, specific training. While some interventions may assist in the process of confronting couples’ intimacy and sexuality, there are also online forums such as “Making Love after Making War”, which provides military veterans and their families a place to discuss sexual and intimacy-related healing.

Providing Supportive Couples Therapy may also help in decreasing overall interpersonal distress and increase focus on partner support. A relationship cannot survive in the long-term if only one individual – or no one at all – is working toward accomplishing a fulfilling life; in other words, creating a sense of balance and a new mission based on understanding.

In effort to educate and apply the appropriate intervention, a therapist may seek to help the couple understand trauma that exists in the relationship – military or not. After trauma is addressed and validated, the therapist can then provide the psychoeducation and positive coping strategies to deal with symptoms related to post-war life.

From de-escalating arguments to developing a safety plan in the event of violent behaviors, interventions can allow the couple and therapist to discuss emotional and physical concerns of everyday living. Role-playing exercises and encouraging couples to participate in activities with one another would also contribute to the development and strengthening of intimate bonds and effective communication.

**Tackling Outdated Puritanical Policy**

Possible interventions for early life trauma through adulthood needs to be addressed and considered when addressing not only veteran reintegration, but veteran health care policy. Advocacy for sexuality, intimacy, health, and post-war reintegration must continue to connect issues with emotional distress from combat, polytrauma and how they relate to the reintegration process and long-term positive coping strategies.

Benefits policies as they stand with VA impact adequate and needed care for veterans and military couples experiencing sexual and intimate dysfunction. According to VA (2013) benefits coverage in Chapter 2, Section 23.1, Part V states sex therapy is an exclusion to coverage and is cited as “services and supplies are viewed as preventive care and are not covered.” This means counseling services for sex therapy, sexual advice, sexual behavior modification or other similar services are not specifically covered under VA care.
When sexual dysfunction and intimacy deficits exist due to trauma acquired in combat service, one would be inclined to not minimize the reintegration obstacle as a mere preventative care measure that is unnecessary in overall wellness and direct services. If the relationship and intimacy difficulties exist as a result of combat trauma or other military related injuries, then we are far past the phase of preventative care and fully engaged in damage control.

As a result of institutional neglect or bias, veteran health care through VA remains inadequate. Whether one wants to debate American puritanical hypocrisy and sexual suppression (Fessenden, Radel, & Zaborowska, 2014) or much needed structural changes within the VA health care system, policy must change and properly trained mental health professionals must be allowed to engage with couples who need them most in the post-war reintegration process.

A Professional Approach

Mental health professionals looking to assist military and veteran couples in achieving peak intimacy and sexuality in the wake of post-war injuries and trauma may do well to not only review and research related materials, but to consider AASECT certification.

Clinicians can make an impact by advocating for military families, parent-parent or couples without children, by gaining the training necessary in understanding underlying, complex issues and being able to be a direct resource in therapy. While VA Health Systems have a way to go in revising policy and catching up to veterans needing sex therapy-related services, mental health professionals working with combat veterans can be frontline therapists or effective advocates in pushing for sound policy changes that will positively impact military and veteran marriages and families.

Questions regarding psychosexual and relationship history may help clinicians gain further insight as to what clients need. A comprehensive account of sexual history, attitudes, and beliefs and how combat has altered perception and sensation disability can possibly aid clients in clarifying sexual concerns throughout treatment.

Normalizing and validating concerns, in addition to providing support for couple and individuals dealing with post-war trauma, may also lead to further exploration into sexuality and intimacy. Inviting speakers to veteran-specific events to discuss success stories in overcoming sexual and intimacy dysfunction may also help normalize feelings of anxiety relating to dysfunction.

When it comes to sexuality and intimacy, it is not enough to simply tackle outdated policies that shy away from love and sex. Sex must not be reduced to a violent, emotionless *wargasm* in a post-war homecoming. Therefore, we must take the steps as professionals to help single and married combat veterans realize what genuine intimacy truly entails. As mental health professionals working with combat veterans, let us proceed with an open mind and remember that everyone not only needs love and the opportunity to live a fulfilled life, but they need to know what that looks like as well.

References


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